DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **01-15**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **X** AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 * **($ -0-**
b. FFY 2003 * **($19,678,790))**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Page 8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Page 8

10. SUBJECT OF AMENDMENT:

Payments for services – Prospective Reimbursement Plan For Nursing Care Facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: **NOT RQUIRED**

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Buell

13. TYPED NAME:
Carmen Hooker Buell

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 25, 2001

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 1, 2001

18. DATE APPROVED:
December 26, 2001

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

*** State Agency authorized "pen and ink" change to show Federal fiscal years in #7.**

FORM HCFA-179 (07-92)

Medical Assistance
State: North Carolina

Payment for Services - Prospective Reimbursement Plan for Nursing Care Facilities

(E) The sum computed for each category in (c)(4)(D) of this Section shall be the price level adjustment factor for that category of rates (direct or indirect) for the coming fiscal year.

(F) However, effective October 1, 1997 for fiscal year 1998, the price level adjustment factors calculated in (c)(4)(E) of this Section shall be adjusted to 2.04% for direct rates and 1% for indirect rates, in order to produce fair and reasonable reimbursement of efficient operators.

(G) Effective October 1, 2001, the price level adjustment factors calculated in (c)(4)(E) of this Section shall not exceed that approved by the North Carolina General Assembly. If necessary, the Division of Medical Assistance shall adjust the annual price level adjustment factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations.

(d) The skilled and intermediate direct patient care rates for new facilities are established at the lower of the projected costs in the provider's Certificate of Need application inflated from the projected opening date in the Certificate of Need application to the current rate period in which the facility is certified based on the price changes as set forth in Rule .0102(c) or the average of industry base year costs and adjusted for price changes as set forth in Rule .0102(c) of this Section. A new facility receives the indirect rate in effect at the time the facility is enrolled in the Medicaid Program. In the event of a change of ownership, the new owner receives the same rate of payment assigned to the previous owner.